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In the Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION, AS *AMICUS CURIAE* IN SUPPORT OF THE RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

The National Employment Lawyers Association (NELA) and its 67 state and local affiliates have a membership of over 3,000 attorneys, and NELA is the country's only professional membership organization of lawyers who regularly represent employees in labor, employment and civil rights disputes. NELA supports precedent-setting litigation affecting the rights of individuals in the workplace. NELA has filed *amicus curiae* briefs before this Court and numerous courts of appeals regarding the proper interpretation and application of the Employee Retirement Income Security Act (ERISA) to ensure that the rights of workers are fully protected. For example, NELA participated in filing *amicus curiae* briefs in this Court's decisions in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); and *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999).

ERISA was enacted to protect the rights of employees and beneficiaries who participate in private, employer-sponsored employee benefit plans. In NELA's view, the treating physician rule, which is at issue in this case, protects employees who become disabled and need access to the disability benefits that they have earned through their employment. Those who review disability claims must exercise their discretion in a manner consistent with both the protections of the statute and their fiduciary duties under the benefit plan.

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[1] Pursuant to Supreme Court Rule 37.6, *amicus* states that no person or entity other than the *amicus curiae*, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. Written consent to the filing of this brief has been obtained from the parties in accordance with Supreme Court Rule 37.3(a). Copies of the consent letters have been filed with the Clerk.

For these reasons, *amicus* respectfully requests that the Court consider its views in support of the Respondent.

SUMMARY OF ARGUMENT

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court explained, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts §187, cmt. d (1959)). Since that time, "courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000). Recently the Court pondered the same question in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 2169 n.15 (2002) ("It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest.").

After *Firestone*, the circuits have struggled mightily to find a reasonable and workable methodology for determining whether an employee benefit plan fiduciary has abused its discretion in its decision to deny benefits. Although most of the case law has applied Factor Six of Comment d to § 187 of the Restatement (Second) of Trusts, *Nord v. The Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002), allows this Court to examine both Factor Four and Factor Six, and to give much needed guidance in how courts should apply these factors. Factor Four provides that the existence of an external standard by which the reasonableness of the fiduciary's conduct can be judged is relevant to a determination of whether there has been an abuse of discretion. Factor Six provides that the existence of a conflict of interest is also relevant to this determination. *Nord* concluded that the plan administrator's decision to ignore treating physicians' opinions, as well as inconsistencies in the plan's positions and irregularities in the administrative process, tended to show that the fiduciary allowed its conflict of interest to infect its decision. In applying the "abuse of discretion" standard, the courts first determine if the denial of benefits is "wrong"—just as they would under the *de novo* standard of review. If the plan grants discretion to the fiduciary, the court then must decide how much discretion to give a conflicted fiduciary, or to a fiduciary who ignores an objective external standard. A "wrong" decision by a conflicted fiduciary who ignores an objective external standard without explanation, whose financial interests are directly advanced by a benefits denial, and who has demonstrated a lack of objectivity in the handling of the claim, should not be enforced.

Amicus submits that the time has come for this Court to put meat on the bones of Restatement § 187 cmt. d, to instruct the lower courts as to how the Restatement "factors" are to be taken into account, and to inform the lower courts of what to do when those factors are present.

The determination of what constitutes a conflict of interest, and how the conflict weighs as a "factor," has plagued courts for the last fourteen years, resulting in essentially five different standards among the circuits: a conflicted decision is presumptively void (Eleventh Circuit); a conflicted decision is presumptively void if there is evidence tending to show that the conflict infected the decision (Ninth Circuit); abuse of discretion will still be applied, but with "more bite" (First Circuit); if a plaintiff produces "smoking gun" evidence proving that a conflict infected the decision, then the standard of review is *de novo* (Second Circuit); and various sliding scale approaches (remaining circuits). *Amicus* urges the Court to

provide clear guidance to the lower courts on this issue so as to curb the enormous amount of litigation and utilization of judicial resources that this issue has generated. *Amicus* recommends the Eleventh Circuit's approach as a clear and workable standard: a conflicted administrator's decision will stand only if the administrator can show that there was no self-interest in making a decision that would be "wrong" under *de novo* review. *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1556-68 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

ARGUMENT

I. INTRODUCTION

In some circuits, plan administrators, particularly insurance companies, have been given *carte blanche* to act as the sole arbiters of claims despite their self-interest in denying those claims. This case presents the Court with the opportunity to redress this untenable situation, and to apply reasonable limitations on the administrators' powers by recognizing the inherent unfairness in allowing one party to a dispute the unfettered discretion to also decide it.

We suggest that the Court do so by clarifying how the factors set forth in Comment d to § 187 of the Restatement (Second) of Trusts should be applied; specifically, by adopting the analysis of either the Eleventh Circuit or the Ninth Circuit. Such an approach strikes a balance between recognition of the trust nature of the relationship between the plan participant and the plan administrator and protection of the participant from the unfairness that may result from giving the administrator virtual *carte blanche*, regardless of its bias.

II. THE RESTATEMENT (SECOND) OF TRUSTS ENUMERATES FACTORS THAT COURTS SHOULD APPLY IN DETERMINING WHETHER THERE IS AN ABUSE OF DISCRETION.

The Restatement (Second) of Trusts § 187, "Control of Discretionary Powers," states: "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion." Comment d provides:

> *Factors in determining whether there is an abuse of discretion.* In determining the question whether the trustee is guilty of an abuse of discretion in exercising or failing to exercise a power, the following circumstances may be relevant: (1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or nonexistence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

Id.

In actions brought challenging the denial of benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), where the plan document gives the administrator discretion to make eligibility determinations and to construe the terms of the plan, several factors identified in Comment d will remain constant because ERISA controls the purpose of the trust, and plans and insurance policies have now adopted boilerplate language granting discretion. Therefore, the extent of the discretion, the purpose of the

trust, and the nature of the administrator's power will be largely identical in the vast majority of such actions. *See Brown*, 898 F.2d at 1564-65 (noting that the purpose of the trust and the nature of the administrator's power "have a constant quality dictated by ERISA."). By contrast, the remaining factors—the existence of an external standard by which to judge the reasonableness of the administrator's action, the motives of the administrator, and the existence of a conflicting interest—may differ significantly in each action.

Following this Court's decision in *Firestone*, courts for the most part have focused on the question of whether the administrator is guilty of an abuse of discretion due to the existence of a conflict of interest and the corollary question of what evidence is necessary to establish such a conflict. An exploration of the motives of the administrator, where such motives can be discerned, has generally been subsumed into the analysis of the administrator's actual or potential conflict of interest. The existence of an external standard by which the reasonableness of the administrator's conduct can be judged has remained relatively unexplored by the courts, but provides another useful method for determining whether an administrator is guilty of an abuse of discretion.

III. THE TREATING PHYSICIAN RULE PROVIDES AN EXTERNAL STANDARD AGAINST WHICH THE ADMINISTRATOR'S DECISION MAY BE JUDGED UNDER RESTATEMENT § 187 CMT D, FACTOR (4). VIOLATION OF THAT STANDARD, WITHOUT A REASONABLE EXPLANATION, SHOULD RESULT IN A COURT'S UNWILLINGNESS TO ENFORCE A WRONG DECISION.

The treating physician rule, when correctly stated, provides just the sort of objective and external standard

contemplated by the Restatement. However, neither Petitioner nor its *amici* have accurately presented the issue set forth in *Nord* or in its predecessor, *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. Jun 13, 2002) (No. 01-1840). Nor has there been an accurate presentation to this Court as to the meaning of and history behind the Social Security Administration's "treating physician rule." *Nord* and *Regula* did not use the treating physician rule as a rule of default; instead, the plan's violation of the rule was presented as a factor to be considered in applying the discretionary standard of review.

As the Restatement (Second) of Trusts notes, one relevant factor for courts to evaluate in determining whether the administrator is guilty of an abuse of discretion is to examine the reasonableness of the administrator's or fiduciary's decision in light of an external standard where such a standard exists. The Restatement (Second) of Trusts § 187, cmt. d. The treating physician's opinion on medical issues (including, e.g., the medical necessity of a treatment and a claimant's limitations) is just such an external standard by which a court can judge the fiduciary's conduct. The treating physician has the most direct clinical information about the claimant, makes determinations in accordance with professional medical standards, and is bound to provide truthful information about the claimant's medical condition and limitations. *See, e.g., Murray v. Heckler*, 722 F.2d 499, 502 (9th Cir. 1983). Accordingly, the treating physician's opinion provides an external measure against which the administrator's decision may be judged for reasonableness.

A. Origin of the Treating Physician Rule

The development of the treating physician rule in Social Security cases resulted from a recognition that "disability"

is a concept that may be statutorily or contractually defined, but requires an individualized assessment to determine whether a particular claimant meets that definition. Neither the Listing of Impairments (20 C.F.R. § 404, Regulations No. 4, Subpart P, Appendix 1), nor the Medical-Vocational Rules (20 C.F.R. § 404, Regulations No. 4, Subpart P, Appendix 2), can completely resolve the question of whether an individual is incapable of engaging in "any substantial gainful activity" for purposes of Social Security Disability Insurance. 42 U.S.C. § 423(d)(1)(A) (Social Security definition of "disability").

The treating physician rule was developed to protect Social Security disability claimants against arbitrary decision-making. Although Administrative Law Judge ("ALJ") decisions are subject to judicial review, 42 U.S.C. § 405(g), that review is deferential; and the ALJ's decision will be upheld so long as it is supported by substantial evidence. In *Richardson v. Perales*, 402 U.S. 389, 401 (1971), this Court defined substantial evidence as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." (citations omitted). Thus, the treating physician rule was adopted as a means "for courts to introduce judicial discretion into their review of the disability determinations made by the [ALJ]." Schneider, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 391 (1996). However, neither the case law that preceded the promulgation of a specific regulation adopting the treating physician rule, nor the regulation itself (20 C.F.R. §§ 404.1527, 416.927), requires abject deference to the treating doctor's opinion, as Petitioner's "Question Presented" implies. Nor, in either *Nord* or *Regula*, is there an unquestioning acceptance of the treating doctor's opinion as Petitioner and its *amici* claim. Courts are fully capable of recognizing that there are circumstances that may preclude acceptance of the treating doctor's opinion, and they have applied the treating physician rule in a sensible and practical manner.

B. Courts Find the Treating Physician Rule to Be Useful and Reasonable, and It Should Be Incorporated into ERISA Jurisprudence.

Absent deference to the treating physician's opinion, claimants may unfairly suffer the denial or termination of benefit payments under plans and insurance policies containing discretionary language. In many cases, plan participants lack a reasonable opportunity to protect against the denial or loss of benefits so long as an insurer, supposedly acting in a fiduciary capacity, can proffer the opinion of a consulting physician who certifies non-disability even in the absence of an examination. Without the treating physician rule, the treating doctor's opinion can be simply disregarded in favor of a clearly less qualified opinion. Under a deferential standard of review, that benefits denial would stand.

Nord offers a clear example of such a situation. There, the Ninth Circuit found "the administrator appears merely to have preferred to rely upon the more favorable conclusions of its own examiner." *Nord v. The Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002). The treating physician rule guards against such actions. At the same time, as the Ninth Circuit has made clear, the treating physician rule in ERISA cases "is not absolute." *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1140 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. Jun 13, 2002) (No. 01-1840). The plan administrator may reject the treating physician's opinions, so long as the administrator provides "specific, legitimate reasons that are based on substantial evidence in the record." *Id.* at 1147.

Now that the treating physician rule has been incorporated into regulations (20 C.F.R. §§ 404.1527; 416.927), the Social Security Administration has clarified the basis of the principle:

> Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.

20 C.F.R. § 404.1527(d)(2).

Nonetheless, the treating physician's opinion will not control unless it meets carefully defined criteria. For example, the longer the treatment relationship and the more times the treating doctor has examined the patient, the more informed is the "longitudinal picture" of the claimant's impairment. 20 C.F.R. § 404.1527(d)(2)(I). The nature and extent of the treatment relationship is also important. Of the greatest significance, though, is that for the treating physician's opinion to be given controlling weight, it must be supportable; i.e., it must be consistent with "medical signs and laboratory findings" and with the record as a whole. 20 C.F.R. §§ 404.1527(d)(3) and (4). Moreover, more weight is given "to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist." 20 C.F.R. § 404.1527(d)(5).

Hence, although these are regulations promulgated by the Social Security Administration rather than the courts, they were developed as a policy that "takes into account the concerns raised by the . . . courts." 56 Fed. Reg. 36932, 36950 (1991). Since those same policy concerns are equal-

ly applicable to issues arising in disability benefit claims brought under ERISA, these straightforward, commonsense principles are a useful external standard in adjudicating such claims because it cannot be disputed that "the effects of medical conditions on individuals vary so widely, and because no two cases are ever exactly alike." *Id.* at 36934. In other words, the treating physician rule strives for a greater measure of accuracy in resolving a "decision-making procedure [that] includes a certain amount of subjectivity and individualization." Schneider, 3 U. CHI. L. SCH. ROUNDTABLE 391, 402.[2]

Although the Petitioner and its *amici* have expressed concern about the honesty of the treating physician, of greater concern to the court in *Regula* was

> the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts. Especially in cases such as this one, where the plan administrator is also the funding source, these experts have a clear incentive to make a finding of "not disabled" in order to save their employers money and to preserve their own consulting arrangements.

Regula, 266 F.3d at 1143. Moreover, *Regula* explained that courts that have rejected the application of the treating physician rule have done so in the context of health benefit claims, where the physician may have a financial

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[2] Although not every ERISA long-term disability plan uses the Social Security definition of "disability," the treating physician rule should be applied in ERISA jurisprudence because it recognizes that treating physicians' opinions are among the most helpful tools for determining whether an individual meets the plan's definition of disability, since every definition of disability necessitates an informed opinion of the individual's medical condition.

motive to assure payment, unlike disability benefit cases where the patient, not the physician, receives the payment. *Id.* at 1143. The court's differentiation between health benefits claims and disability claims is borne out by the medical articles cited by Petitioner and its *amici*. For example, in Wynia, et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 183 JAMA 1858, 1863 (2000), the authors limited their presentation to medical benefits and, even there, found manipulation of reimbursement rules "relatively uncommon." Another article, Freeman, et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 ARCHIVES OF INT. MED. 2263 (1999), also was restricted to health insurance reimbursement. Neither of these studies provides any support for an argument that a treating physician in a disability case would furnish an opinion that was not warranted by the evidence. Furthermore, the recognized caveats to the application of the treating physician rule operate as a check against such a practice; i.e., if the physician's opinion is inconsistent with the record as a whole, or if that opinion can be disputed by reliance on other clinically supported evidence, then the plan fiduciary does not have to accept it as conclusive.

Thus, the treating physician rule constitutes an application of the *Firestone* instruction to weigh the Restatement factors in determining whether there has been an abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The treating physician rule both provides an external standard for comparing the reasonableness of the administrator's decision, and illuminates whether an administrator has acted in its own self-interest. Both of these are factors in determining whether the administrator has abused its discretion under § 187 of the Restatement (Second) of Trusts.

IV. COURTS NEED GUIDANCE AS TO WHAT CONSTITUTES AN ABUSE OF DISCRETION UNDER THE FACTORS STATED IN *FIRESTONE* AND IN THE RESTATEMENT (SECOND) OF TRUSTS.

Since this Court's decision in *Firestone*, the lower courts have been reviewing decisions of administrators granted with discretionary authority under the abuse of discretion standard. Where the administrator had an actual or potential conflict of interest, the courts have sought to apply a less deferential or more searching standard of review. However, as discussed in detail below, in the fourteen years since *Firestone*, the circuits have been unable to agree upon a workable paradigm for their analysis of what constitutes a potential or actual conflict of interest, and for their analysis of how potential or actual conflicts of interest should be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187). Indeed, courts have even parted company in analyzing whether the distance between abuse of discretion review and *de novo* review can be traversed along a sliding scale or whether a significant violation of one of the Comment d factors means that a court will reverse a wrongful denial. *Compare, e.g., Lang v. Long Term Disability Plan of Sponsor Applied Remote Technology, Inc.*, 125 F.3d 794, 798 (9th Cir. 1997) (if the administrator's decision was tainted by a conflict of interest, then it is entitled to no deference), *with Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000) (adopting a sliding scale analysis which heightens the degree of scrutiny in proportion to the administrator's conflict of interest). *See also Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 2169 n.15 (2002) ("It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest.").

The Court should take this opportunity to clarify how lower courts should determine whether an actual or potential conflict of interest exists, and once such a conflict is found, how it is to be weighed on abuse of discretion review. Such guidance will lead to a more uniform treatment of claims challenging benefit denials under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

V. THE COURTS ARE IN A STATE OF CONFUSION WHEN DETERMINING HOW A CONFLICT AFFECTS THE STANDARD OF REVIEW.

In the aftermath of *Firestone*, the lower courts have adopted essentially five different approaches to determining how the existence of a conflict "weighs" in the review of a discretionary decision. *See* ABA SECTION OF LABOR AND EMPLOYMENT LAW, EMPLOYEE BENEFITS LAW, 2nd ed., 442-48 (2002). The Eleventh Circuit mandates that a conflicted decision is presumptively void. *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990). The Ninth Circuit has established that a conflicted decision is presumptively void if there is evidence tending to show that the conflict infected the decision. *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995); *Lang*, 125 F.3d at 798. The First Circuit finds that abuse of discretion will still be applied, but with "more bite." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999). The Second Circuit employs a standard whereby the plaintiff bears the burden of finding a "smoking gun" necessary to show that a conflict of interest caused the benefit to be denied. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996). The remaining circuits subscribe to some version of a "sliding scale" approach, as described below. The only conclusion that can be drawn from the courts' disarray in the aftermath of *Firestone* is that they need further guidance.

Of these standards, only those of the Eleventh and Ninth Circuits ensure consistent adjudication, with the Eleventh Circuit's standard being the more practical of the two. *Amicus* urges the Court to adopt the standard of either the Ninth or Eleventh Circuit for the reasons set forth in detail below. The approaches of the remaining circuits have resulted in inconsistent results in determining both what triggers the slide down the scale and how far down a court should slide.

A. The Sliding Scale Approach Is Subjective and Has Resulted in Inconsistent Adjudication among the Circuits.

The sliding scale approach is unworkable. Although most circuits claim to use this approach, none are able to use it consistently, as it is an inherently subjective standard. The sliding scale itself, with all of its various gradations and calibrations, is simply impractical, as illustrated by the circuits' differing articulations of it. Indeed, at least two of the circuits that have adopted the sliding scale have explicitly expressed reservations as to its use.

Third Circuit: The Third Circuit explained that in its application of the sliding scale approach, the court "approximately calibrat[es] the intensity of our review to the intensity of the conflict." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000). However, at the same time the court also acknowledged that the standard is "intellectually unsatisfying, or at least discomforting . . . [for] it is not clear how the process required by the typical arbitrary and capricious review changes." *Id.* at 392. Indeed, as the case law reveals, the sliding scale approach is as subjective and impractical as it is vague and imprecise.

Fourth Circuit: The Fourth Circuit in *Elliot v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999), modified the

abuse of discretion standard to the extent necessary to counteract any "influence unduly resulting from the conflict." In *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 233-34 (4th Cir. 1997), the court explained that "[t]he more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it." This explanation, however, only underscores the inevitable subjectivity that results in inconsistent adjudication under the sliding scale approach: the word "more" does not quantify how far down the scale a court should slide. This is an unmanageable test in the guise of guidance to the lower courts.

Fifth Circuit: The Fifth Circuit in *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 297 (5th Cir. 1999) reaffirmed that "[t]he greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be." Again, the words "greater" and "less" defy the possibility of consistent adjudication because they are so vague.

Sixth Circuit: The Sixth Circuit acknowledges that a conflict of interest should be taken into account as a factor in determining whether the decision was arbitrary and capricious, and examines whether the administrator was motivated by self-interest in rendering its decision. *Peruzzi v. Summa Medical Plan*, 137 F.3d 431, 433 (6th Cir. 1998). However, as typical of circuits employing the sliding scale approach, the Sixth Circuit does not articulate a standard for how or to what degree this factor must be taken into account. This kind of vagueness is disturbing and unworkable, as acknowledged by the Seventh Circuit.

Seventh Circuit: In an attempt to apply *Firestone's* instruction to weigh self-interest as a factor in the standard of review, the Seventh Circuit noted the need for additional judicial guidance on this issue: "How *much* does it weigh? [One court] recently concluded that it can't weigh very much without exceeding the judicial capacity to tailor standards of review. Judges understand deferential and non-deferential review, but intermediate variations blur into one another without promoting understanding or consistent adjudication." *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 986 (7th Cir. 1999). The Seventh Circuit got the issue exactly right: terms such as "more" or "greater" or "less" that litter sliding scale adjudication do not answer the question of "how much." However, perhaps for lack of additional guidance, the Seventh Circuit also employs the sliding scale approach, despite questioning its ability to promote "understanding or consistent adjudication." *Id.*; *see also Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997) ("The more serious the conflict, the less deferential our review becomes.")

Eighth Circuit: The Eighth Circuit determined in *Clapp v. Citibank N.A. Disability Plan*, 262 F.3d 820, 827 (8th Cir. 2001) that a court should give less deferential sliding scale review if the claimant produces material probative evidence that a palpable conflict was connected to the administrator's decision so as to cause a serious breach of fiduciary obligation. However, like other circuits, the Eighth Circuit acknowledges that there is an inherent problem with this approach: if the plan participant has produced the required evidence to trigger a sliding scale review, the plan participant also likely would be able to receive a favorable result under the traditional abuse of discretion review. *Barnhart v. UNUM Life Ins. Co.*, 179 F.3d 583, 589 n.9 (8th Cir. 1999) (The standard "presents a considerable hurdle for plaintiffs. Logically, a plaintiff who can show that a conflict of interest or serious procedural irregularity caused a serious breach of

the administrator's fiduciary duty will more than likely have substantial evidence showing that the fiduciary's decision was arbitrary and capricious."). Thus, the Eighth Circuit has acknowledged that its own sliding scale approach is essentially meaningless.

These complex and imprecise standards have created confusion in the circuits, and their misapplication at the district court level generate further appellate review and therefore waste judicial resources. *See, e.g., id.* at 588 (holding the lower court failed to analyze conflict issue under standard of the circuit).

Tenth Circuit: In *Pitman v. Blue Cross*, 217 F.3d 1291, 1295 (10th Cir. 2000), the Tenth Circuit held that the court's deference should decrease in proportion to the severity of the conflict. *Accord McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258-59 (10th Cir. 1998). In *Charter Canyon Treatment Center v. Pool Co.*, 153 F.3d 1132, 1136 (10th Cir. 1998), the Circuit used the vaguest language of all: that the review should be "tempered by" the defendant's possible conflict of interest. Again, however, the Seventh Circuit's apt question of "how much" it should decrease or be "tempered by" remains unanswered under this unworkable standard.

B. The Sliding Scale Approach Generates Inconsistent Approaches Even as to Whether a Financial Conflict of Interest Initiates a Slide Down the Scale.

A particular area of inconsistency that exists among the circuits using the sliding scale standard is the application of the conflict of interest analysis to insurance companies that both fund and administer ERISA plans. Despite the undeniable trust background of ERISA recognized by this Court in *Firestone*, the reality of long-term disability plans today is that they consist overwhelmingly of insurance policies. Even a cursory glance at the plethora of reported cases demonstrates that in the vast majority of cases insurers, who have obvious financial interests at stake, decide the claims.[3] The circuits have attempted to address this reality.

Some circuits hold that when a plan administrator serves in this dual capacity, there is an actual, readily apparent conflict of interest. *See, e.g., Killian v. Healthsource Provident Admin., Inc.*, 152 F.3d 514, 521 (6th Cir. 1998); *Pinto*, 214 F.3d at 384; *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996). These courts note that "insurance companies have an active incentive to deny close claims in order to keep costs down and keep themselves competitive . . . ." *Pinto*, 214 F.3d at 388.

The Seventh Circuit, however, holds that where a fiduciary acts in such a capacity, only a potential conflict exists and the insurer is presumed to be neutral. *Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), *cert. denied*, 525 U.S. 947 (1998). In *Mers*, the Seventh Circuit found that no conflict existed essentially because the insurer was a "Fortune 500" company and the impact of granting the particular benefit sought in the instant case was minuscule. *Id.* at 1020-21. Following the Seventh Circuit's analysis to its logical conclusion means an insurer, which likely has billions of dollars in assets, would never be deemed to have a financial incentive to deny a claim, because no

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[3] Under the abuse of discretion standard, absent proper application of the Restatement factors, these insurers essentially "serve as judge and jury" for claims against themselves. Conferring such power on a potentially self-interested private party is unprecedented in American jurisprudence. It is also in direct contradiction to the considered determinations of the courts and legislatures of virtually every state that insurance company claim practices must be regulated carefully so as to protect insureds.

single disability claim could possibly be more than minuscule. Of course, this ignores the reality that the cumulation of claims (and potential claim denials) obviously affects any insurer's "bottom line." The Seventh Circuit's superficial analysis in *Mers* demonstrates that the often present "judicial hesitation" to question a fiduciary's motives, even when the fiduciary is an insurance company, can leave beneficiaries unprotected. *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (espousing a burden-shifting analysis to place the onus on the fiduciary to show lack of improper influence over decision when such conflict exists).

C. The First Circuit's "More Bite" Approach Is Another Version of the Subjective Sliding Scale Approach, and Is Equally Unworkable.

The First Circuit has avoided using "sliding scale" terminology; instead, it characterizes the lesser deference afforded to plan decisions influenced by a conflict of interest as being arbitrary and capricious review with "more bite." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (holding that "fine gradations in phrasing are as likely to complicate as to refine the standard," and that the "essential requirement of reasonableness has substantial bite itself"). However, the "more bite" approach is just as vague as the sliding scale approach, and cannot ensure consistent adjudication. "Bite" is, at best, just another subjective term, like "sliding scale," and at worst, an approach rendered meaningless by its lack of definition. Thus, in criticizing the "more bite" approach, the Seventh Circuit aptly noted that courts using this standard of review "have never come up with an operational definition of 'more bite' or a specification of the appropriate circumstances for mastication." *Perlman*, 195 F.3d at 981.

The vagueness of the "more bite" standard is illustrated in *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181 (1st Cir. 1998). There, a divided appellate panel seemingly applied the "more bite" analysis to the same record reviewed by the district court and reversed the district court's decision, with little explanation or guidance. If, as the circuit courts recognize, the sliding scale approach lacks clarity and workability, the district courts will certainly have difficulty applying the "more bite" standard, as evidenced by *Doyle*. Thus, litigants and the lower courts lack guidance as to how cases should be presented and decided in the presence of a conflict of interest.

D. The Second Circuit's Approach Also Is Unworkable.

In the Second Circuit, the plan participant must produce "smoking gun" evidence that proves that the administrator's decision was infected by the conflict of interest in order to receive anything but traditional, non-sliding abuse of discretion review. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996) (holding that plaintiffs have the burden of proving that the conflict of interest affected the administrator's decision). This standard is in direct conflict to *Firestone's* instruction that a conflict of interest must be weighed as a "'facto[r] in determining whether there is an abuse of discretion.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (quoting Restatement (Second) of Trusts § 187). In addition, because this standard requires the plaintiffs to *prove* that an administrator acted on a conflict, it requires them to conduct extensive discovery in order to locate a "smoking gun" showing the conflict, and then go even further to show that the conflict in fact influenced the decision at hand.

Beneficiaries have little chance of finding a "smoking gun" to prove that the administrator acted on a conflict. *See, e.g., Pinto*, 214 F.3d at 379. ("Our rule is also informed by the understanding that 'smoking gun' direct evidence of purposeful bias is rare in these cases so that, without more searching review, benefits decisions will be virtually immunized."). Consequently, it should not be the burden of the beneficiary "'to show that the fiduciary succumbed to this temptation, that he acted in bad faith, that he gained an advantage, fair or unfair, that the beneficiary is harmed.'" *Brown*, 898 F.2d at 1565, quoting *Fulton Nat'l Bank v. Tate*, 363 F.2d 562, 571-72 (5th Cir. 1966).

VI. IT IS TIME FOR THIS COURT TO SET FORTH A CLEAR AND WORKABLE STANDARD FOR DETERMINING WHETHER THERE HAS BEEN AN ABUSE OF DISCRETION

As explained above, the circuits are in disarray about what constitutes a conflict of interest, how it is to be demonstrated, and how to weigh evidence of it. Clearly, the lower courts are in need of a uniform, rational, and practical approach. Both the Eleventh and the Ninth Circuits have established approaches that provide clear standards for assessing whether a conflict of interest is present, and for determining the standard of review in light of that conflict. Both circuits employ a burden-shifting approach when there is evidence of a conflict of interest. *Brown*, 898 F.2d at 1566-68; *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995). As discussed below, the Eleventh Circuit approach provides the clearer standard.

A. The Eleventh Circuit Has Established a Workable Standard Which Will Result in Consistent Adjudication.

In *Brown*, the Eleventh Circuit established a burden-shifting analysis. When the plan participant shows that the administrator was acting under a potential conflict of interest, the burden shifts to the administrator to prove that its decision was not tainted by that conflict. 898 F.2d at 1566-68. Under the Eleventh Circuit's approach, a court first determines whether, looked at from a *de novo* perspective, the administrator's decision is "wrong." *Id.* at 1567 n.12 If the decision would not be wrong under a *de novo* review, then the administrator's decision stands. If the decision would be wrong under a *de novo* review, then the court examines the conflict of interest. Upon this examination, if the administrator was acting under a substantial conflict of interest, then the burden shifts to the administrator to prove its decision was not tainted by self-interest. *Id.* at 1566-67. A financial conflict, such as that which exists when the same party both funds the plan and decides claims, constitutes a substantial conflict of interest. *Id.* at 1561-62, 1568. Indeed, the Eleventh Circuit has stated that an insurance company's

> fiduciary role lies in perpetual conflict with its profit-making rule as a business. . . . Decisions made by the issuing company on behalf of a plan based on a contract of insurance . . . inherently implicate the hobglobin of self-interest. Adverse benefits determinations save considerable sums that are returned to the fiduciary's corporate coffers.

Id. A plan administrator may meet its burden of proving that it did not act in a self-interested manner by, for example, showing that its decision is intended to maxi-

mize benefits to all plan participants in a fiscally responsible way. *Id.* at 1568.[4]

B. The Ninth Circuit Also Employs a Clear Standard

Like the Eleventh Circuit, the Ninth Circuit considers the fact that the administrator both funds and administers the plan to be an "inherent" conflict of interest. *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997). However, for this conflict to affect the standard of review, the beneficiary must come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show" that the administrator acted on the conflict. *Atwood*, 45 F.3d at 1323.

The Ninth Circuit has found the following evidence to be "material" and "tending to show" that the administrator acted on the conflict: inconsistencies in the plan administrator's reasons for denying the claim, *Lang*, 125 F.3d at 799; insufficiency of a plan administrator's reasons for denying the claim, *Tremain v. Bell Industries, Inc.*, 196 F.3d 970, 977 (9th Cir. 1999); procedural irregularities in the processing of claims, *Freidrich v. Intel Corp.*, 181 F.3d 1105, 1110 (9th Cir. 1999); and, the current subject of the Court's review, rejection of the treating physicians' opinions, *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1147 (9th Cir. 2001), *petition for cert. filed*, 71 USLW 3001 (U.S. Jun 13, 2002) (No. 01-1840).

If the beneficiary produces the required evidence, then the burden shifts to the administrator to show that its determination was not affected by a conflict of interest. *Atwood*, 45 F.3d at 1316. Like the Eleventh Circuit, the

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[4] This is particularly relevant in the case of plans with a fixed corpus, as opposed to insurance companies, for example.

Ninth Circuit proposes that a plan might meet this burden by, for example, "showing how its decision in fact benefitted the plan as a whole . . . [or] that its decision was intended to prevent an unanticipated expenditure that would have depleted the resources available to other beneficiaries of the plan." *Lang*, 125 F.3d at 798. If the administrator cannot meet its burden of showing that its decision was not tainted by self-interest, then the court reviews the determination *de novo*, "without deference to the administrator's tainted exercise of discretion." *Atwood*, 45 F.3d at 1323.

C. Adopting One of These Approaches Will Result in Conserved Judicial Resources and Will Help Fulfill ERISA's Intent.

Adopting either the Eleventh or the Ninth Circuit approach would eliminate substantial conflict within the circuits, and would ensure that a cohesive approach would be uniformly applied throughout the circuits. Moreover, the burden shifting approach of these Circuits makes sense both as a practical matter and as a matter of fulfilling ERISA's intent to protect participants' benefits. As the Eleventh Circuit aptly stated, "[t]he judicial hesitation to inquire into the fiduciary's motives will leave the beneficiaries unprotected unless the existence of a substantial conflicting interest shifts the burden to the fiduciary to demonstrate that its decision is not infected with self-interest." *Brown*, 898 F.2d at 1565-66.

In addition to protecting beneficiaries, the burden-shifting approach is both reasonable and practical because it does not require plaintiffs to somehow locate a "smoking gun" to prove that the conflict infected the administrator's decision, which, as discussed above, is "rare in these cases." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 379 (3d Cir. 2000).

Although both the Ninth and the Eleventh Circuits employ a burden-shifting approach, the difference between their approaches is when the burden shifts. In the Ninth Circuit, although the plan participant does not have to discover a "smoking gun" that definitively shows that the administrator acted on a conflict, the participant must put forth evidence "tending to show" that the administrator acted in its own interest (in addition to showing the "inherent" financial conflict of interest). *Atwood*, 45 F.3d at 1323; *Lang*, 125 F.3d at 797. Once the beneficiary has proffered this evidence, the burden shifts to the administrator to rebut it. *Atwood*, 45 F.3d at 1323. In the Eleventh Circuit, however, the burden shifts when there is a financial or other conflict of interest present. *Brown*, 898 F.2d at 1561-62, 1568. It is then the responsibility of the administrator to show that it did not act on this conflict. *Id.* at 1566-67. The Eleventh Circuit's approach is a clearer standard because it eliminates inevitable inconsistencies in what constitutes evidence "tending to show" a conflict and avoids the need for plaintiffs to conduct discovery to obtain substantial evidence of the conflict outside of the administrative record.[5] Thus, although both approaches are better than the current state of the other circuits, where there are virtually no concrete standards to ensure consistent adjudication, the Eleventh Circuit provides the better approach.

Moreover, both approaches avoid the amorphous and inherently subjective determinations inherent in the sliding scale and "more bite" approaches. Under either the Eleventh Circuit or the Ninth Circuit approach, there is no need to determine the degree of the fiduciary's conflict,

[5] Moreover, it is not logical to assume that in every case in which a financial motive affects an administrator's substantive decision, there also will be some procedural irregularity or other manifest misconduct that is known to the participant and therefore available to demonstrate that the conflict affected the decision.

nor is there any need to determine how far the court should slide away from deference to the administrator's decision or how much more "bite" it should put into its deferential review. In short, where a decision would be wrong under a *de novo* standard and the insurer or other plan fiduciary is unable to demonstrate that the conflict did not affect its decision, then the decision constitutes an abuse of discretion.

Furthermore, these approaches ensure the enforcement of ERISA's duty of loyalty, since administrators will be aware that if they act disloyally, courts will review their decisions *de novo*. As the Solicitor General noted in his *Amicus Curiae* brief in the present matter, "[t]o be sure, once an employer establishes a plan covered by ERISA, plan administrators are fiduciaries, 29 U.S.C. 1002(21)(A), and must administer the plan consistent with their duties of prudence and loyalty." Brief for the United States as *Amicus Curiae* Supporting Petitioner at 12. The approaches of the Eleventh and Ninth Circuits help ensure that administrators adhere to their obligations of loyalty, since if there is evidence that they did not act with loyalty to the beneficiaries, and the administrator cannot rebut this evidence, then a court will review the administrators' decisions *de novo*. Administrators therefore will not be able to hide behind the shield of "discretion" when they have failed to act with the loyalty required of them.

It is true that most employers try (and succeed) in being fair to their employees. However, insurance companies, who handle the bulk of non-pension benefit claims, have more palpable conflicts that may give rise to a greater temptation to disregard ERISA's duty of loyalty. *See, e.g.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 2169 n.15 (2002) (noting in dictum that there is a "potential for conflict when an HMO makes decisions about appropriate treatment," and that under *Firestone*, "review for abuse of discretion would home in on any

conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised,") (citations omitted). As the Eleventh Circuit noted in *Brown*, a fundamental difference between plans administered by insurance companies and plans "that are truly trusts" is that trustees act for the future well-being of the trust, but this cannot be presumed for insurance companies, since "[a]dverse benefits determinations save considerable sums that are returned to the fiduciary's corporate coffers." 898 F.2d at 1567-68. It is for this reason that courts must have an effective tool for admonishing administrators who have disregarded their duty of loyalty: namely, a *de novo* standard of review when a financial conflict of interest is present.

CONCLUSION

For the reasons stated above, this Court should uphold the ruling below, and use this case as an opportunity to give the lower courts the tools to render consistent adjudication for which they have been searching for fourteen years.

Respectfully submitted,

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